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MASSACHUSETTS HEALTH REFORM LEGISLATION 2008-2012

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ISSUE

This report briefly summarizes specified aspects of Massachusetts' health reform legislation in 2008, 2010, and 2012. The report also provides a brief comparison to Connecticut law, when applicable.

SUMMARY

In 2006, Massachusetts enacted comprehensive health reform legislation aimed at ensuring that all residents have health insurance coverage. In 2008, 2010, and 2012, additional legislation made significant changes to a variety of health care topics:

- Chapter 305 of the Acts of 2008, An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care.
- Chapter 288 of the Acts of 2010, An Act to Promote Cost Containment, Transparency, and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses.
- Chapter 224 of the Acts of 2012, An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency, and Innovation.

This report briefly summaries several features of these laws, focusing on major provisions affecting:

1. price transparency;
2. electronic health records and information sharing among providers;

3. administrative efficiencies (such as uniform billing and coding requirements);

4. insurance product and contracting reforms;

5. oversight and regulation of provider mergers and consolidation;

6. certification of accountable care organizations (ACOs);

7. state agencies involved in overseeing and implementing these provisions; and

8. state investments in these areas such as investments in community hospitals and other small providers, state support for e-health implementation, workforce investments, and tax credits.

The report is organized by topic. For each topic, the report provides an overview of significant features of Massachusetts law as it stands today (after the passage of all three acts and other amendments), followed by a brief discussion of comparable Connecticut law, if any.

Please note that this report summarizes Massachusetts' law and is not a comprehensive analysis of these topics or the legislation as a whole, which contained provisions not discussed in the report. For more detailed information on the acts, see the Sources and Additional Information section below.

PRICE TRANSPARENCY

Provider Disclosure

Massachusetts law requires health care providers, upon request, to disclose in advance the allowed amount or charge for a procedure, service, or admission, including any required facility fees. (The "allowed amount" is the contractually agreed amount paid by an insurer to a provider.) Providers must do this within two working days after a current or prospective patient requests it. If unable to quote a specific amount due to the inability to predict a patient's specific treatment or diagnostic code, the provider must instead disclose the estimated maximum allowed amount or charge.

If a provider participates in an insurance network, the provider must give patients, upon request, sufficient information about the proposed service so that they may use their insurers' toll-free telephone number and website to determine their out-of-pocket costs (see below) (Mass. Gen. Laws Ann. ch. 111, § 228).

Connecticut. Connecticut law does not have a general requirement for health care providers to disclose charges in advance. However, the patients' bill of rights for hospitals and long-term care institutions requires that patients, prior to or at admission and during their stay, be fully informed of services available in the facility and related charges, including charges for services not covered by Medicare, Medicaid, or the basic per diem rate (CGS § 19a-550(b)). Also, Connecticut law requires doctors and certain other providers who recommend diagnostic tests, to the extent they are reasonably able, to inform the patient of the approximate range of costs of the test (CGS § 20-7a).

Insurer Disclosure

Massachusetts law requires health insurers to establish a toll-free telephone number and website that enables consumers to request and obtain real-time cost estimates for medical care, including the estimated amount the patient is responsible for paying. This includes any facility fee, copayment, deductible, coinsurance, or other out of pocket cost. The cost estimate is considered binding, but insurers are not required to cover the cost of unanticipated care not included in the original estimate. Insurers must alert consumers that the actual amount they will be responsible to pay may vary based on such unforeseen services (Mass. Gen. Laws. Ann. ch. 176O, § 23; ch. 32A, § 27).

Connecticut. Connecticut law does not require insurers to provide such a website. Connecticut does require insurers to print on their membership or identification cards a toll-free telephone number for utilization review and benefit determinations (CGS § 38a-591b).

Consumer Health Information Website

Massachusetts law requires the state's Center for Health Information and Analysis (CHIA), in consultation with certain other entities, to maintain a consumer health information website. Among other things, the website must contain information (1) comparing the quality, price, and cost of health care services and (2) about provider and payer achievement of health care cost benchmarks and growth goals. The website must be designed to assist consumers in making informed decisions about their medical care and informed choices among providers (Mass. Gen. Laws. Ann. ch. 12C, § 20).

Connecticut. Connecticut does not currently have a comparable website. Connecticut's all-payer claims database (APCD), which is not yet operational, will contain certain information for consumers on health care costs and quality. The law requires the Connecticut Health Insurance Exchange to use the data in the database to provide the state's health care consumers with information about the

cost and quality of health care services so that they may make economically sound and medically appropriate health care decisions (CGS § 38a-1091). The database is projected to be available to consumers in the fourth quarter of 2015.

Reporting Requirements

Massachusetts law establishes various reporting requirements for (1) institutional providers and their parent organizations and other affiliates, (2) registered provider organizations, and (3) private and public health care payers and third-party administrators (Mass. Gen. Laws. ch. 12C, §§ 8 – 10). These reports include information on health care pricing and insurance premiums. CHIA must use this information for various purposes, such as (1) the consumer website, (2) an all-payer claims database, and (3) analyzing health care spending trends as compared to the annual health care cost growth benchmark established by the state's Health Policy Commission. (The cost growth benchmark is the targeted growth of total health care expenditures, tied to the growth rate of potential gross state product; for more information, see OLR Report 2014-R-0259.)

Connecticut. Connecticut law also establishes various reporting requirements for hospitals, providers, and insurers, including certain pricing information. For example, each hospital must file with the Office of Health Care Access its current pricemaster (detailed schedule of charges). As another example, when the APCD is operational, insurers and various other entities will be required to report claims information. The reporting requirement is tentatively set to begin with test data in the second quarter of 2015.

HEALTH INFORMATION TECHNOLOGY (IT) AND PROVIDER INFORMATION SHARING

Statewide Health Information Exchange

Massachusetts law requires the Executive Office of Health and Human Services (EOHHS) to implement and maintain a statewide health information exchange that connects to health care provider electronic health records (EHR) systems. The office (1) enters into contracts to purchase and develop the infrastructure to implement the exchange and (2) oversees the technical aspects of its development and implementation (Mass. Gen. Laws Ann. ch. 118I, § 13).

The law also created a 21-member Health IT Council within EOHHS to coordinate with other state agencies, government entities, and stakeholders in developing and implementing the exchange. It also administers the state's Health Information Exchange Fund, created by law to fund the exchange's development (Mass. Gen. Laws Ann. ch. 118I, § 10).

***Exchange Implementation Plan*.** The law requires the council, in consultation with EOHHS and the E-Health Institute (see below), to develop and annually update a statewide health information exchange implementation plan that includes a budget for Health Information Exchange Fund expenditures (Mass. Gen. Laws Ann. ch. 118I, § 5).

Among other things, the plan must:

1. allow seamless, secure electronic exchange of health information among providers, insurers, and other authorized users;

2. provide consumers with secure, electronic access to their own health information;

3. meet all federal and state privacy and security requirements, including those imposed by the federal Health Insurance Portability and Accountability Act (HIPAA);

4. establish a method enabling patients to choose which health providers can share their personally identifiable information;

5. assess municipal and regional readiness to implement and use EHR systems among providers;

6. provide public health reporting capability as required under state law; and

7. allow reporting of non-identifiable health information for purposes EOHHS deems necessary (Mass. Gen. Laws Ann. ch. 118I, § 5).

Exchange Requirements. By law, the exchange must:

1. allow patients to "opt-in" or "opt-out" at any time;

2. prohibit providers from accessing any part of a patient's EHR unless the patient chooses to participate in the exchange;

3. maintain patients' personally identifiable health information in physically and technologically secure environments; and

4. allow patients to request from their provider a list of individuals and entities that have accessed their personally identifiable health information (Mass. Gen. Laws Ann. ch. 118I, §§ 11 & 13).

The law requires EOHHS to develop and distribute written guidelines for participating in the exchange to potential and authorized users. It must also, in consultation with the e-Health Institute (see below), ensure that the exchange and associated provider EHR systems comply with state and federal privacy requirements (Mass. Gen. Laws Ann. ch. 118I, § 1 et seq.).

Mass HIway. In 2012, Massachusetts launched Mass HIway, the first statewide health information exchange funded by the federal Centers for Medicare and Medicaid Services (CMS) (the state received a $17 million federal grant). It enables the secure electronic transfer of patient health information among health care providers, hospitals, pharmacies, long-term care facilities, laboratories, and other health care entities. Providers may send and receive health information to obtain complete patient medical histories and coordinate care.

Provider Compliance*.* Starting January 1, 2017, Massachusetts law requires all health care providers to implement fully interoperable EHR systems that connect to the statewide health information exchange. Providers who fail to do so are subject to penalties, unless they apply to EOHHS for a waiver from the requirement. The office may grant a waiver only if a provider proves that he or she does not have broadband internet access. Any penalties EOHHS collects must be deposited into the Prevention and Wellness Trust Fund. The fund is administered by the Massachusetts public health department to support the state's effort to meet its health care cost growth benchmark (Mass. Gen. Laws Ann. ch. 111, § 2G; ch. 118I, § 9).

Connecticut. Connecticut currently does not have an operational statewide health information exchange. 2014 legislation repealed the statutes establishing the Health Information Technology Exchange of Connecticut (HITE-CT), a quasi-public agency charged with (1) developing a statewide health information exchange and (2) providing grants to advance health IT and exchange in the state, among other things (PA 14-217). The legislation transferred many of HITE-CT's responsibilities to the Department of Social Services (DSS).

A nonprofit organization, eHealth Connecticut, currently assists providers with the conversion to interoperable EHR systems. DSS contracted with the organization to implement a health information exchange pilot program to demonstrate the technology and benefits of EHR systems for providers and patients. The project connects a small number of community health centers, hospitals, and private physician practices to the exchange.

Massachusetts E-Health Institute

Massachusetts law created an e-Health Institute (MeHI), a quasi-state agency to advance the use and dissemination of health IT across the state. MeHI is part of the Massachusetts Technology Collaborative, a public economic development agency that works to support statewide economic growth.
By law, MeHI must consult with the Health IT Council to:

1. help health care providers and organizations implement and use interoperable EHR systems that connect to the statewide health information exchange;

2. support the Health IT Council in creating and maintaining MassHIway;

3. identify and promote accelerated dissemination of emerging health care technologies expected to improve health care quality and reduce costs;

4. help health care providers comply with federal CMS standards for "meaningful use," beyond Stage 1 (see below);

5. promote the quality, cost, and efficiency benefits of EHR systems to patients, providers, and the general public; and

6. administer the state's e-Health Institute Fund (Mass. Gen. Laws Ann. ch. 40J, §§ 6D & 6E).

Statewide EHR Plan. The institute must prepare and annually update a statewide EHR plan, including a budget for e-Health Institute Fund expenditures. It must submit the plan to the Health IT Council for review and comment. By law, the plan must:

1. assess municipal and regional readiness to implement and use interoperable EHR systems for defined patient populations;

2. address the development and implementation of EHR systems among health care providers, particularly those serving underserved populations, such as community health centers and behavioral health providers;

3. allow seamless, secure electronic exchange of health information among providers, insurers, and other authorized users;

4. comply with all federal and state privacy and security requirements;

5. meet all interoperability standards the institute adopts;

6. support any activities funded by the Healthcare Payment Reform Fund;

7. give patients the option of allowing only designated providers to disseminate their personally identifiable health information; and

8. allow reporting of non-identifiable health information for purposes the federal Department of Health and Human Services deems necessary (Mass. Gen. Laws Ann. ch. 118I, § 5).

Evaluation. Massachusetts law requires the Health IT Council and MeHI to evaluate the effectiveness of their expenditures from the Health Information Exchange Fund and the e-Health Institute Fund, respectively. Among other things, the evaluation must include the extent to which their respective programs (1) increased the adoption of EHR systems by providers, (2) reduced health care costs or growth trends, and (3) increased provider compliance with CMS meaningful use standards. The council and MeHI must report by March 31, 2016 their findings, recommendations, and any necessary legislation to the chairs of the House and Senate Committees on Ways and Means and the Joint Committee on Health Care Financing (Mass. Chapter 224 of the Acts of 2012, § 240).

Connecticut. Connecticut does not currently have a similar entity. After HITE-CT was eliminated in 2014, DSS assumed responsibility for (1) implementing and periodically revising the statewide health IT plan and (2) establishing electronic data standards to facilitate the development of integrated EHR systems for state-funded providers and institutions. By law, the statewide plan must include, among other things, (1) such electronic data standards and (2) general standards and protocols for health information exchange. DSS must annually submit the plan to the Appropriations, Human Services, and Public Health Committees. The first submission was due January 1, 2015.

Health IT Requirements for Physicians

Starting January 1, 2015, Massachusetts law requires physicians to meet certain health IT requirements in order to obtain or renew a state license. Specifically, applicants must demonstrate proficiency in the use of (1) computerized physician order entry, (2) e-prescribing, (3) EHR, and (4) other forms of health IT determined by the Board of Registration in Medicine (the state medical board). At a minimum, "proficiency" means that applicants must comply with federal CMS "meaningful use" requirements (45 CFR Part 170) (Mass. Gen. Laws Ann. ch. 112, § 2).

The federal American Recovery and Reinvestment Act authorized CMS to create Medicare and Medicaid EHR incentive programs that provide financial incentives to eligible professionals and hospitals for the "meaningful use" of certified EHR technology to improve patient care. Providers may qualify for either the Medicare or Medicaid incentive program, but not both.

The federal incentive programs are phased in over three stages with increasing requirements. Stage 1 began in 2011 and focused on providers capturing patient data and sharing it with the patient or other health care providers. Stage 2 began in 2014 and focuses on health information exchange between providers and giving patients secure online access to their health information. Stage 3 is scheduled to begin in 2016 and will focus on improving health care outcomes (CMS has not yet adopted final regulations for this stage). Additional program information is available on the CMS website.

According to the Massachusetts Medical Society, approximately 10,000 physicians would be unable to obtain meaningful use certification by 2015. For example, hospital-based specialists (e.g., radiologists, pathologists, etc.) and surgeons do not qualify for the CMS EHR incentive programs. In 2014, the Massachusetts legislature considered, but did not pass, legislation that would instead require applicants for a physician license to demonstrate to the state medical board that they use or know how to use "digitized patient-specific clinical information" (2014 HB 3903).

However, in December 2014, the Board of Registration in Medicine finalized regulations that establish multiple ways in which physicians can demonstrate compliance with the meaningful use requirement. For example, physicians can demonstrate proficiency by (1) having a relationship with a hospital certified by CMS as meeting the meaningful use requirements, (2) completing at least three hours of continuing medical education on EHR, or (3) becoming an authorized MeHI user.

The regulations also establish a broad set of exemptions for certain physician license categories where EHR use is inherent or irrelevant, such as interns and residents, applicants for administrative or volunteer licenses, and applicants serving in the military or called into service during an emergency.

The regulations take effect January 2, 2015, but physicians renewing their licenses before March 31, 2015 will receive a one-time waiver from the requirements (243 CMR 2.00 et seq.).

Health IT Requirements for Hospitals and Community Health Centers

Massachusetts law required the state public health department to adopt regulations requiring hospitals and community health centers to implement computerized physician order entry (COPE) and EHR systems in order to obtain or renew a state license. These systems must be certified by the Certification Commission for Healthcare Information Technology (CCHIT) and comply with CMS meaningful use standards.

The regulations establish different implementation dates for each type of facility. For example, non-acute hospitals must implement certified EHR and COPE systems by October 1, 2015. Acute hospitals must phase-in implementation between December 1, 2013 and December 1, 2015 (Mass. Chapter 305 of the Acts of 2008, §§ 36-37 & 105 CMR § 130.375).

Health IT Requirements for Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes

Massachusetts law requires (1) state-certified ACOs and patient-centered medical homes and (2) risk-bearing provider organizations to have an interoperable EHR system to coordinate care, share information, and prescribe electronically by December 31, 2016 (Mass. Chapter 224 of the Acts of 2012, § 243).

Connecticut. Connecticut does not require the above providers and facilities to demonstrate health IT proficiency as a condition of licensure. (Connecticut does not license or certify ACOs or patient-centered medical homes.) The law allows licensed providers to use electronic prescribing systems, transmit prescriptions through electronic data intermediaries, and maintain electronic health records. It also requires hospitals to establish protocols for using electronic signatures for medical records (CGS §§ 19a-25a, 19a-25b, & 19a-25c).

State Assistance for Health IT

Massachusetts law created certain initiatives to help health care providers develop and implement health IT infrastructure. For example, MeHI's Health Information Technology Revolving Loan Fund provides zero-interest loans to providers and community-based behavioral health organizations to develop and implement interoperable health IT systems that comply with state and federal requirements (Mass. Gen. Laws Ann. ch. 40J, § 6E 1/2).

As another example, the e-Health Institute Fund provides two-year grants to help certain providers with health IT costs, including EHR systems. Grants are available to providers who are (1) ineligible for Medicare or Medicaid incentive payments under the federal Health Information Technology for Economic and Clinical Health

Act or (2) eligible for such payments, but do not have access to the resources necessary to implement EHR systems. Grant recipients must fully implement an EHR system within two years of receiving the grant and report to MeHI certain quality improvement data (Mass. Gen. Laws Ann. ch. 40J, § 6D).

Some hospitals are also eligible for IT financial assistance from the state's Distressed Hospital Trust Fund. The Massachusetts Health Policy Commission administers this fund, which must be consistent with MeHI activities, among other things. The law includes the adoption of health IT and interoperable EHR systems among the purposes for which funds may be used (Mass. Gen. Laws Ann. ch. 29, § 2GGGG).

Finally, MeHI created a pilot program with the community colleges and vocational technology schools to support health IT curriculum and workforce development. The program is funded by the state's Health Care Workforce Transformation Trust Fund (Mass. Gen. Laws Ann. ch. 40J, § 6D).

Connecticut. Connecticut law does not expressly establish similar initiatives, however some state agencies may provide such assistance to health care providers and organizations.

Other Provider Information Sharing

Massachusetts implemented additional initiatives to improve information sharing among providers. For example, state law required the Public Health Department, in collaboration with the University of Massachusetts Medical School, to create an "Academic Detailing" program for prescribing practitioners. This education and outreach program arranges for physicians, pharmacists, and nurses to conduct face-to-face visits with prescribing practitioners and provide them with:

1. evidenced-based information on the cost-effectiveness and therapeutic effects of prescription drugs and

2. information regarding drug marketing designed to prevent competition to brand-named drugs from generics or other evidenced-based treatment options (Mass. Gen. Laws Ann. ch. 111, § 4N).

The National Resource Center for Academic Detailing website provides additional information regarding such programs at http://www.narcad.org/about/aboutad/.

ADMINISTRATIVE EFFICIENCIES

Standard Prior Authorization Form

Under Massachusetts law, all health plan carriers must use a standardized prior authorization form (Mass. Gen. Laws Ann. ch. 176O, § 25). The Division of Insurance (DOI) must develop and implement the form, which cannot exceed two pages and must be capable of being sent electronically. A carrier that fails to use or accept the standardized form, or fails to respond within two business days after receiving a completed form from a provider, is deemed to have granted the prior authorization request.

Coding Standards and Standard Claim Formats

Massachusetts law requires all health plan carriers and their subcontractors to accept and recognize patient diagnostic information and patient care service and procedure information consistent with the current HIPAA compliant code sets; International Classification of Diseases; American Medical Association's Current Procedural Terminology codes, reporting guidelines, and conventions; and CMS Healthcare Common Procedural Coding System. The law also requires carriers and their subcontractors to use standardized claim formats for processing health care claims as adopted by the National Uniform Claims Committee and National Uniform Billing Committee under HIPAA (Mass. Gen. Laws Ann. ch. 176O, §§ 5A & 5B). Similar requirements apply to the state regarding Medicaid patients and claims (Mass. Gen. Laws Ann. ch. 118E, § 62).

Connecticut. Connecticut law requires health care providers to submit all third-party claims for payment on the current standard Health Care Financing Administration Fifteen Hundred (HCFA1500) health insurance claim form or its successor, or in the case of a hospital or other health care institution, a Health Care Financing Administration UB-92 health insurance claim form or its successor, or in accordance with other forms that the insurance commissioner may prescribe (CGS § 38a-477).

INSURANCE PRODUCT AND CONTRACTING REFORMS

Selective and Tiered Networks

Massachusetts law requires certain health plan carriers to offer plans with selective or tiered provider networks. Specifically, a carrier offering a health benefit plan that provides or arranges for the delivery of health care services through a closed provider network for at least 5,000 eligible individuals, employees, and dependents must offer all eligible individuals and small businesses in at least one geographic

area at least one plan that uses (1) a selective provider network, (2) smart tiering, or (3) a tiered provider network. The plan must provide a premium rate discount of at least 14% compared to a plan that does not use a selective or tiered network (Mass. Gen. Laws Ann. ch. 176J, § 11).

A selective provider network is a provider network that is smaller than a carrier's general provider network. A smart tiering plan is a product in which health care services are tiered and member cost sharing is based on the placement of the services. A tiered provider network plan is a product in which health care providers are tiered and member cost sharing is based on the tier placement of the provider.

Carriers must tier providers based on quality and cost measures. Smart tiering plans may take into account the number of services a provider performs each year. But, for smart tiering plans, if a medically necessary and covered service is available at only five or fewer facilities in the state, health plans cannot place that service in the most expensive cost-sharing tier.

Carriers may reclassify provider tiers or determine provider participation in selective or tiered networks once per calendar year. But they may reclassify a provider from a higher-cost tier to a lower-cost tier or add providers to a selective network at any time. Carriers must (1) notify plan members of network changes at least 30 days before the changes take effect and (2) provide information about selective and tiered networks on their websites.

The law requires DOI to determine the adequacy of selective and tiered networks. DOI may consider such factors as the (1) location of participating providers and enrolled employers or members, (2) range of services provided by participating providers, and (3) plan benefits that recognize and provide for medical needs of members that may not be adequately covered by the participating providers. The DOI must report annually to the legislature its findings and recommendations concerning the selective and tiered networks, including utilization trends and the extent to which they have reduced health care costs.

Prohibited Contracting Practices

Massachusetts law prohibits a carrier from contracting with a health care provider if the contract includes certain provisions, including provisions that:

1. guarantee a provider the right to participate in a selective or tiered network;

2. require the carrier to put all members of a provider group in the same tier of a tiered network or in a selective network;

3. require a provider to participate in a new selective or tiered network without granting the provider the right to opt out of the network;

4. require or permit the carrier or provider to alter or terminate a contract based on contracts with other carriers or providers; or

5. limit the ability of the carrier or provider from disclosing the (a) allowed amount and fees of services to an insured or a treating provider or (b) out-of-pocket costs to an insured (Mass. Gen. Laws Ann. ch. 176O, § 9A).

Medical Loss Ratio

Massachusetts law requires carriers offering health benefit plans to individuals and small groups to report to the DOI their current and projected medical loss ratio (MLR) (Mass. Gen. Laws Ann. ch. 176J, § 6). MLR is generally the percentage of premium dollars that a carrier spends on providing health care and health care quality improvement activities, compared to how much is spent on administrative and overhead costs.

Connecticut. Connecticut law similarly requires carriers to report their MLR to the Connecticut Insurance Department (CID) and disclose it to applicants for coverage (CGS §§ 38a-477c & 38a-478c(4)).

Small Group Rate Filing and Approval

Massachusetts law requires carriers offering small group health insurance plans to file with the DOI base rates and changes to rating factors that are to be effective on January 1 of each year on or by July 1 of the preceding year. The DOI must disapprove any rates that are excessive, inadequate, or unreasonable in relation to the plan benefits and any rating factors that are discriminatory or not actuarially sound (Mass. Gen. Laws Ann. ch. 176J, § 6).

The DOI must presumptively disapprove rates as excessive if (1) administrative expenses increase by more than the most recent percentage increase in the New England medical consumer price index, (2) a carrier's contribution to surplus generally exceeds 1.9%, or (3) the aggregate MLR for small group plans is less than 89% (88% in 2015 and forward). If a rate is presumptively disapproved, the DOI must hold a public hearing on the rate proposal, at which the attorney general may intervene. The carrier must inform all employers and individuals covered under a small group plan that the proposed rate has been presumptively disapproved and is subject to a hearing at the DOI.

Connecticut. In Connecticut, state law requires insurance companies and health maintenance organizations (HMOs) to file proposed rates for individual health policies with the CID for approval. It also requires HMOs to file rates for group health policies (CGS §§ 38a-481 & 38a-183). (The law does not require insurance companies to file rates for small group insurance policies.) The law prohibits excessive, inadequate, or unfairly discriminatory rates. Filed proposed rates for individual insurance policies are (1) subject to the CID's approval and (2) deemed approved if the CID does not disapprove them within 30 days of being filed. For HMOs, the CID must approve or disapprove rates within a reasonable time. Connecticut law does not require a public hearing on a proposed rate filing, though the CID commissioner has discretion to hold one.

Small Group Purchasing Cooperatives

Massachusetts law permits up to six small group purchasing cooperatives, through which small businesses (those with up to 50 eligible employees) can combine to purchase health care coverage as a large group (Mass. Gen. Laws Ann. ch. 176J, § 12). The DOI must establish application and certification processes for the cooperatives. Cooperatives approved by the DOI may cover up to a combined total of 85,000 lives at any given time.

Any health plan a group purchasing cooperative offers must include all state-mandated benefits and access to a wellness program. The plan cannot deny coverage to a person based on his or her health condition, age, race, or sex. The purchasing cooperative cannot charge a small business member a premium rate that is higher than what the carrier would charge a similarly-situated small business that does not participate in the purchasing cooperative.

As a condition of continuing to do business in the small group market in Massachusetts, the law requires any carrier covering at least 5,000 eligible individuals, employees, and dependents to annually file a health plan proposal with each purchasing cooperative for its consideration if the cooperative requests the proposal (Mass. Gen. Laws Ann. ch. 176J, § 13).

Connecticut. Connecticut law permits small employers to join together to purchase insurance (CGS § 38a-560). Under certain circumstances, an association group plan may be exempted from the state's small employer rating law, which restricts what criteria may be used to determine plan premiums. The law permits this exemption if (1) the association offers plans to members as a single entity; (2) it insures at least 3,000 individuals; (3) the offered plans are community rated (i.e., the same

rate is charged for each employee and dependent); and (4) the plans are written on a guaranteed issue basis (CGS § 38a-567(22)). "Guaranteed issue" requires coverage be offered regardless of the health status or prior claims experience of the group's members.

Evaluation of Mandated Health Benefits

Massachusetts law requires legislative committees, when reporting favorably on proposed mandated health benefit bills, to include a review and evaluation of the proposal by CHIA. Upon request of a committee, CHIA must conduct the review and evaluation of the proposal in consultation with relevant state agencies and report to the committee within 90 days after the request. If CHIA does not report within 45 days, the committee may favorably report the bill without a review and evaluation. CHIA's report must include, at a minimum, the (1) financial impact of mandating the benefit; (2) medical efficacy of mandating the benefit; and (3) if the proposal adds coverage of an additional class of practitioners, results of any research demonstrating the medical results achieved by adding those practitioners relative to those already covered (Mass. Gen. Laws Ann. ch. 3, § 38C).

Massachusetts law also requires CHIA to analyze the cost and public health impact of existing mandated health benefits every four years. CHIA must consult with the Department of Public Health and the University of Massachusetts Medical School to ensure that all mandated benefits continue to meet clinical standards of care. The law permits CHIA to file legislation to amend or repeal mandated benefits that no longer meet those standards (Mass. Gen. Laws Ann. ch. 3, § 38C(e)).

Connecticut. Connecticut law allows for cost-benefit analyses of existing and proposed insurance mandates to be performed through the CID (CGS § 38a-21). PA 09-179 established the health benefit review program within the CID, which must evaluate the social and financial impacts of mandated health benefits that (1) existed in statute or were effective on July 1, 2009 and (2) the Insurance and Real Estate Committee requests annually by August 1, including proposed legislation. The insurance commissioner must report findings to the committee by the following January 1. The law requires the commissioner to contract with the UConn Center for Public Health and Health Policy to conduct the analyses. It also authorizes him to assess insurers for the program's costs. For more information about the health benefit review program, including reports completed to date, see the CID's website.

PROVIDER MERGERS AND CONSOLIDATIONS

Massachusetts law requires a health care provider or provider organization (e.g., hospital, physician organization, provider network, etc.) to notify the Health Policy Commission at least 60 days before making any material change to its operations

or governance structure (e.g., mergers, acquisitions, non-profit hospital conversions, etc.). Within 30 days after receiving the notice, the commission must conduct a preliminary review of the proposed transaction. The commission may conduct a cost and market impact review (CMIR) if it determines that the proposal will significantly impact the (1) competitive market or (2) state's ability to meet its health care cost growth benchmark (Mass. Gen. Laws Ann. ch. 6D, § 13).

The CMIR examines how the proposal affects short- and long-term health care spending, quality of care, and patient access to services. Some examples of the factors it may examine include:

1. the provider's or provider organization's size and market share, medical expenses, and patient care quality;
2. the proposal's impact on existing health care providers and competing options for health care service delivery;
3. the provider's or provider organization's role in serving at-risk, underserved, and public assistance patient populations, including those with mental health and substance abuse conditions; and
4. consumer concerns.

The commission must issue a preliminary CMIR and identify any provider or provider organization that:

1. has a dominant market share for the services it provides,
2. charges prices for health care services that are materially higher than the median prices charged by other providers for the same services in the same market, and
3. has a health status adjusted total medical expense that is materially higher than the median total medical expense for all other providers for the same services in the same market.

The provider or provider organization may respond in writing to the preliminary CMIR findings within 30 days after it is released, after which the commission must issue its final CMIR. The final CMIR may identify areas for further review or monitoring, or be referred to other states agencies. For example, the commission must send the final CMIR to the attorney general if it identifies any provider or provider organization that meets the above listed criteria.

While the commission cannot approve or deny a proposed transaction, the law prohibits such a transaction from taking effect until 30 days after the commission issues its final CMIR.

The commission may also conduct a CMIR of any provider organization the CHIA identifies as having exceeded the state benchmark for health care cost growth in the previous calendar year (Mass. Gen. Laws Ann. ch. 6D, § 13).

Connecticut. In Connecticut, PA 14-168 requires parties to certain transactions that materially change the business or corporate structure of a medical group practice to notify the attorney general (AG) at least 30 days before the transaction's effective date. The act also requires parties to certain transactions involving a hospital, hospital group, or health care provider that are subject to federal antitrust review to (1) notify the AG and (2) upon request, provide him a copy of the information filed with the federal agencies. The AG must maintain and use any of the above written information he receives in compliance with the Connecticut Antitrust Act.

Under the act, a group practice's business or corporate structure is materially changed if the group practice engages in any of certain transactions (e.g., merger, consolidation, or affiliation) with (1) another group practice resulting in a group practice of eight or more physicians or (2) a hospital, hospital system, captive professional entity, medical foundation, or other entity organized or controlled by the hospital or hospital system. For more information, see the full Public Act Summary.

In both states, a nonprofit hospital needs the state's approval before converting to for-profit-status (e.g., a sale to a for-profit purchaser). For more information, see OLR Reports 2013-R-0321 and 2014-R-0185 (describing the Massachusetts and Connecticut requirements, respectively).

STATE CERTIFICATION OF ACOS

ACOs are voluntary networks of physicians, hospitals, and other health care providers that share financial and medical responsibility for care provided to a population of patients. Massachusetts law requires the Health Policy Commission to establish a process for certain registered provider organizations to be certified as ACOs. Certification is voluntary. The purpose of the certification process is "to encourage the adoption of integrated delivery care systems in the commonwealth for the purpose of cost containment, quality improvement and patient protection."

The commission must establish minimum standards for certified ACOs, with requirements on a range of topics. The law also allows the commission to establish additional standards, and sets forth a list of goals it must consider when developing such standards. The commission must also create a designation process for model ACOs. This designation is for "ACOs that have demonstrated excellence in adopting the best practices for quality improvement, cost containment and patient protections."

The law requires the commission to create a process to review an ACO's decision to refuse to allow a medical provider to provide free-standing, ancillary services to ACO patients (Mass. Gen. Laws Ann. ch. 6D, § 15).

To the extent state-funded insurance programs determine that ACOs offer opportunities for cost-effective and high quality care, the programs must prioritize certified and model ACOs for the delivery of publicly funded health services, provided these ACOs, to the extent possible, assure continuity of patient care (Mass. Chapter 224 of the Acts of 2012, § 268).

STATE AGENCIES PROVIDING OVERSIGHT OF HEALTH REFORM PROVISIONS

Massachusetts law charges various state agencies with overseeing and implementing provisions of the above health reform legislation, including the (1) Department of Public Health, (2) Division of Insurance, (3) Office of Medicaid, (4) Commonwealth Health Insurance Connector Authority, (5) Department of Revenue, and (6) Office of the Attorney General.

The law also creates two new state agencies to implement these provisions: the Center for Health Information and Analysis (CHIA) and Health Policy Commission (HPC).

CHIA

CHIA is an independent state agency that serves as the state's primary source of health care data collection and analysis. It assumed most, but not all, of the functions of its predecessor agency, the Division of Health Care Finance and Policy.

Among other things, CHIA:

1. collects, analyzes, and disseminates health care information to help in the (a) formulation of health policy and provision and (b) purchase of health care services;

2. manages the state's All-Payer Claims Database;

3. collects, analyzes, and disseminates information regarding providers, provider organizations, and payers to increase the transparency and improve the functioning of the health care system;

4. collaborates with the legislature and other states agencies to collect and disseminate data on the cost, price, and functioning of the state's health care system and the health status of its residents;

5. participates in and provides data analysis for the Health Policy Commission's annual hearings on health care provider and payer costs, prices, and cost trends;

6. reviews and comments on all capital expenditure projects requiring a determination of need from the state health department;

7. maintains a consumer website created by the now defunct Health Care Quality and Cost Council; and

8. reports to consumers comparative health care cost and quality information.

Additionally, the law requires CHIA to analyze health care spending trends and publish an annual health report based on data submitted by payers and provider organizations as well as data from the HPC's Cost and Market Impact Reviews. The report must compare the state's total health care expenditures and growth rates with the HPC's health care cost growth benchmark.

CHIA is led by an executive director who is chosen by a majority vote of the Governor, Attorney General, and State Auditor to serve a five-year term. It is funded by an annual assessment on acute hospitals, ambulatory surgical centers, and surcharge payors (Mass. Gen. Laws ch. 12C, § 2 et seq.).

HPC

The HPC is an independent state agency created in 2012. The commission replaced the state's Health Care Quality and Cost Council and is charged with (1) developing health policy to reduce overall health care cost growth and improve quality of care and (2) monitoring the state's health care delivery and payment systems.

Among other things, the commission establishes annual statewide benchmarks for the growth of total health care expenditures (the 2014 benchmark is 3.6%). It also tracks changes in the health care provider market, such as mergers, consolidations, and nonprofit hospital conversions (see above for more information on oversight of provider consolidations).

The commission is governed by an 11-member board. Its day-to-day operations are supervised by an executive director, who manages a staff of 40 to 50. There is also an advisory council to the commission, with representatives from various components of the health care system.

Currently, the commission is funded through the state's Health Care Payment Reform Fund, which includes revenue from (1) a one-time assessment on certain acute hospitals and surcharge payors (such as insurers) and (2) certain one-time gaming licensing fees. Starting July 1, 2016, the commission will be funded by an annual assessment on acute hospitals, ambulatory surgical centers, and surcharge payors (Mass. Gen. Laws ch. 6D, § 6). For more information, see OLR Report 2014-R-0259.

Connecticut

Connecticut does not have comparable state entities, however certain existing state agencies perform some of these functions.

INVESTMENTS

In addition to budgetary allocations, the Massachusetts legislation created certain industry assessments to pay for various programs. The largest assessment was a one-time $225 million assessment on certain acute hospitals ($60 million) and surcharge payors (such as insurers) ($165 million). (The assessment could be paid in four annual installments, with the first payment due June 30, 2013.) In general, the hospital assessment applied to hospitals or hospital systems with more than $1 billion in net assets and less than 50% of revenues from public payers (Mass. Chapter 224 of the Acts of 2012, § 241).

The majority of revenue from the assessment is directed to the Distressed Hospital Trust Fund. The remaining revenue is directed to the Prevention and Wellness Trust, e-Health Institute Fund, and Health Care Payment Reform Fund.

Financial Assistance for Community Hospitals and Other Facilities

Massachusetts law includes several initiatives providing funding for community hospitals or other health care facilities. For example, through the Distressed Hospital Trust Fund, the Health Policy Commission awards grants on a competitive basis to nonprofit, nonteaching hospitals to support several purposes. A hospital is ineligible if its relative prices are above the statewide median relative price (Mass. Gen. Laws Ann. ch. 29, § 2GGGG). This grant program is known as the Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program.

According to the commission's website, the commission awarded $10 million in Phase 1 of the program (with awards ranging from $65,000 to $500,000) and will award up to $60 million in Phase 2 (with awards of up to $6 million per hospital). Total available funding will be $119 million over four years.

Among other things, the Massachusetts legislation also:

1. authorized Community Hospital and Community Health Center Capital Reserve Funds, with proceeds from bonds secured by these funds used to provide financial assistance to nonprofit community hospitals or nonprofit community health centers (Mass. Gen. Laws Ann. ch. 69 App. § 2-10) and

2. established a special commission to study the capital needs of community hospitals (Mass. Chapter 288 of the Acts of 2010, § 60).

Connecticut. Connecticut does not provide comparable grant funding for hospitals. Connecticut provides grants-in-aid to community health centers and primary care organizations for equipment, renovations, improvements, and expansion of facilities, including acquisition of land or buildings. The grants-in-aid are funded with general obligation bonds. From 1997 through 2011, the state authorized approximately $23.2 million in bonds for this purpose. In 2012, the state authorized an additional $30 million in bonds, for $15 million grants to two designated entities (PA 12-189).

Workforce Investments

Massachusetts law includes a number of provisions concerning the expansion of the health care workforce, with a focus on primary care providers.

For example, legislation created a Health Care Workforce Center within the Department of Public Health, with various responsibilities related to the recruitment and retention of health care workers, particularly primary care providers. Among other things, the center must (1) monitor trends in access to primary care, behavioral health, and certain other providers and (2) take various steps to address health care workforce shortages (Mass. Gen. Laws Ann. ch. 111, § 25L).

The center administers the Health Care Workforce Loan Repayment Program. The program provides repayment assistance for physicians, nurses, physician assistants, and behavioral health providers who work in certain clinical fields and agree to work for at least two years in a medically underserved area (Mass. Gen. Laws Ann. 111, § 25N).

Massachusetts law established a Primary Care Residency Grant Program to finance the training of primary care providers at teaching community health centers (Mass. Gen. Laws Ann. 111, § 25N ½). The law also established a Primary Care Workforce Development and Loan Forgiveness Grant Program, to enhance recruitment and retention of primary care physicians and other clinicians at community health centers (Mass. Gen. Laws Ann. 111, § 25N ¾). These programs are funded through the Health Care Workforce Transformation Fund.

Among other provisions related to health care workforce development, the Massachusetts legislation also:

1. required the University of Massachusetts medical school to (a) expand its entering class and increase residencies for graduates committed to working in primary care in underserved regions and (b) establish an enhanced tuition waiver program for students committing to work for at least four years in primary care, community service, or underserved areas (Mass. Chapter 305 of the Acts of 2008, §§ 31 and 32) and

2. created a fund to increase the number of nursing faculty and students (id. § 33).

Connecticut. In Connecticut, the Primary Care Office within the Department of Public Health conducts "research and analysis of the healthcare delivery system and the population it serves to identify trends in access and develop strategies to address deficiencies." In cooperation with the federal Health Resources and Services Administration, the office "works with health care providers and communities to improve access to care for the underserved, by recruiting and retaining providers to practice in federally designated shortage areas."

While Connecticut law provides for certain health care provider loan repayment or forgiveness programs, these programs are not currently funded (CGS §§ 10a-162a and 19a-7d).

Wellness Program Tax Credit for Small Businesses

In addition to various other prevention and wellness initiatives, Massachusetts law provides a wellness program tax credit for small businesses. Eligible employers may qualify for a tax credit of up to $10,000 per year, for up to 25% of the costs of implementing a certified wellness program for employees.

To qualify, businesses must employ fewer than 200 employees and meet other criteria. Total credits are capped at $15 million annually. The credit program is scheduled to sunset at the end of 2017 (Mass. Gen. Laws ch. 62, § 6N; ch. 63, § 38FF; Mass. Chapter 224 of the Acts of 2012, §§ 238, 239).

SOURCES AND ADDITIONAL INFORMATION

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